MEDICAID HOSPICE REVOCATION

State Form 48735 (4-98) / OMPP 0007

The information contained on this completed form is **CONFIDENTIAL** according to 405 IAC 1-16, 5-2-10.1, 5-2-10.2,

A. RECIPIENT INFORMATION	Primary hospice diagnosis (*ICD-#*):
Name of recipient (*last, first, middle initial*)	Recipient's Medicaid number
Recipient's Social Security number	

B. PROVIDER INFORMATION	
Name of Hospice Provider	Hospice Medicaid Provider number

C. REVOCATION STATEMENT

(a) **The Medicaid Hospice Program** has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitations of this program and the terms of the revocation of these services;

(b) **I understand** that by signing this revocation statement I will, if eligible, resume Medicaid coverage of benefits waived when the hospice care was elected;

(c) **I will forfeit** ALL hospice coverage days remaining in this benefit period;

(d) **I may at any time** elect to receive hospice coverage for any other hospice benefit period for which I am eligible.

D. SIGNATURES	
Signature of recipient (*or recipient representative*)	Date
Signature of witness	Date